

# TORONTO PAIN CLINIC

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## PAIN MANAGEMENT REQUISITION FORM

Is this patient a:  New patient  Re-Referral

### PATIENT INFORMATION

Name \_\_\_\_\_ HCN: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Tel.: \_\_\_\_\_ Alt. Tel.: \_\_\_\_\_

If the patient has 3rd party coverage, which insurance provider? \_\_\_\_\_

### PHYSICIAN INFORMATION

Primary Physician: \_\_\_\_\_ CPSO# \_\_\_\_\_ Billing # \_\_\_\_\_

Address \_\_\_\_\_

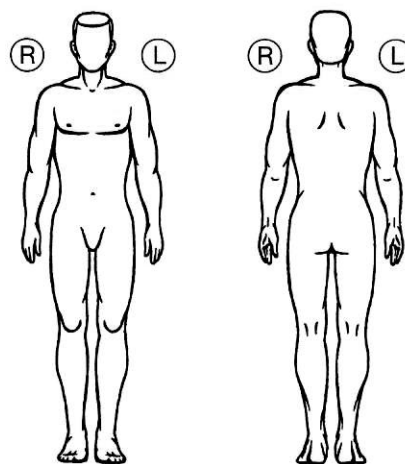
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

### REASON FOR REFERRAL

#### Please Check if Applicable:

- Neck Pain  Fibromyalgia
- Back Pain  Facial Pain
- Migraine  Headache NOS
- CRPS/RSD  Neuropathic Pain
- Trigeminal Neuralgia  mTBI
- Postherpetic Neuralgia  TMJ
- MVA-related  Radiculopathy
- Persistent Post-Surgical Pain
- Other: \_\_\_\_\_

#### Please circle area of pain



FRONT

BACK

#### History of Drug/Alcohol abuse?:

- Yes  No

#### Current Medications

#### Medical history

#### Diagnostic Imaging (if any)

#### Previous Pain Treatments:

#### Referred for (check one):

- Pain Management
- Post MVA Rehabilitation
- Independent Assessment
- WSIB
- General Referral

#### Insurance:

- Personal Injury  Extended Benefits  WSIB  OHIP
- Other: \_\_\_\_\_

Normal time for processing referrals at Toronto Pain clinic is between 2 to 3 days.

Referring Physician's Name (Print Clearly)

Referring Physician's Signature

Date